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Message From the President

Colleagues:

Nurses from around the country gathered in Orlando, Florida recently to participate in the Center for American Nurses’ Annual Education event. LEAD Summit 2009 was thought provoking, stimulating, and great fun! If you were unable to join us, this issue of NURSES FIRST will give you a taste of what you missed. In addition, this issue is filled with articles and tips that will help you strengthen your relationships with professional colleagues and tackle the challenges you face each and every day. As always, at the Center we are focused on our collective mission of providing excellent patient care and creating healthy work environments. On behalf of the Center for American Nurses Board of Directors, we hope you find the information included in this issue helpful.

Sincerely,

Dennis Sherrod, EdD, RN
President
Center for American Nurses
Center for American Nurses Mission, Vision, Purpose, and Values

**Mission**
To create healthy work environments through advocacy, education, and research

**Vision**
The leader in workforce advocacy for professional nurses

**Purpose**
To articulate, advocate, and provide workforce advocacy solutions to equip nurses in shaping their work environment

**Values**

- **Leadership:** Resolve professional workforce issues; act as professional resource; provide role models for the balance between personal and professional life

- **Personal and Professional Development:** Encourage individual nurse initiative in creating a healthy work environment and advocating for change in a positive persistent manner

- **Partnership:** Build collaborative organizational and individual relationships beneficial to The Center and its professional work

- **Stewardship:** Manage and develop The Center’s human and financial resources

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Taking Charge: What Every Charge Nurse Needs to Know

BY ROSE O. SHERMAN, EdD, RN, NEA-BC, CNL AND TERRY EGGENBERGER, RN, MSN, PhD (c)

“I am just not sure that I am ready to take charge. I know I have leadership skills but I am a relatively new nurse. Am I really ready to assume all this responsibility? My nurse manager thinks I have excellent leadership potential and is encouraging me to take the plunge. But what if the staff does not respect me in the role and what if I fail?”

In today’s turbulent health care environment, it is not unusual for nurses to feel the type of anxiety that the nurse quoted above recently conveyed to one of the authors about assuming charge nurse responsibilities. Charge nurses are expected to lead staff while managing the work systems and processes on their units to insure that the needs of patients are met. It is a skillful balancing act and not all organizations provide the type of leadership training that the charge nurse may need (Hansten, 2008; Hudson, 2008; Sherman, 2005). Yet despite the challenges, embracing the role of charge nurse can provide enormous professional satisfaction and a tremendous leadership growth experience. Important keys to success in becoming an effective charge nurse include understanding the role responsibilities and developing the skills needed to enhance communication, reduce conflict and build team synergy.

Taking Charge

Defining the role of the charge nurse is not easy in today’s healthcare delivery systems due to the inconsistencies in definition and scope across facilities. The title of charge nurse has been around since the early 1980’s. One definition for a charge nurse that has been given is “nurses assigned to a particular unit designated by the head nurse to coordinate nursing activities on a particular shift” (Connelly, Nabarrete, & Smith, 2003, p. 204). Sometimes, a title other than charge nurse may be used such as unit coordinator or shift coordinator. The role may include expanded responsibilities such as conducting performance evaluations, scheduling, payroll, and chairing committees. The charge nurse role may be formal or informal. In some facilities, the role rotates between the various senior level nurses on a shift. In other organizations, the role is more formalized as a designated support position primarily held by one individual, with a relief person on the weekends. Some charge nurses are designated to be a resource for the rest of the team but maintain responsibility for their own patient assignment. If a facility is unionized, the union contracts may prohibit the use of a formal charge nurse role.

Charge nurses have accountability to the organization, staff and patients for the care that is delivered. Organizations depend on charge nurses to be the gatekeepers for safe and efficient care, which meets regulatory requirements and ensures an economic return. Charge nurses conduct real time assessments of unit productivity during various points throughout the shift. They often determine how staff resources will be distributed on their shift, or the upcoming shift in response to changing institutional and patient needs. Charge nurses must also be familiar with the institutions policies and procedures in order to navigate through what is often a very complex system.

Charge nurses set expectations for staff and provide support so that staff can carry out those expectations. They are expected to hold staff accountable for performance of their professional patient care duties, adherence to regulatory requirements, and documentation of this essential information. The charge nurse serves as the conduit for information provided from staff to management and from management to staff. Charge nurses assist with the orientation, training and professional development of staff. They play a key role in the competency assessment process.

Charge nurses are often clinical experts in their areas of assignment. Their expertise allows them to engage with the staff nurses in clinical decision making and problem solving. During their shift of responsibility, charge nurses manage
people, patient flow, use of equipment, and unit communication to ensure that the patients and staff get the support that they need. In order to manage all of these responsibilities, charge nurses must be able to effectively delegate and supervise care.

**Delegating and Supervising Nursing Care**

Many charge nurses find it difficult to delegate tasks to other members of their health care team. When done well, delegation can be a very effective management tool. It frees professional nurses to attend to more complex client needs, develop the skills of nursing assistive personnel and promote cost containment for the organization (NCSBN, 2005). Ineffective delegation or a lack of follow-up supervision for tasks delegated can result in errors or omissions of care (Hansten, 2008). Dr. Linda Mahimeister, an attorney and nurse expert in the area of charge nurse accountability, recently noted in an interview that from a legal standpoint, charge nurses are expected to make decisions about allocating care based on staffing and patient needs. They will also be held accountable to provide surveillance and supervision of the care they delegate (Federwisch, 2008).

Most states provide specific guidance about the delegation of nursing care in their professional practice acts and nursing administrative rules/regulations. The National Council of State Boards of Nursing (NCSBN, 2005) describes delegation as the transfer of authority by a qualified nurse to a competent individual for the purpose of completing selected tasks or activities. The assignment should be based on the assessment of the patient’s needs and the scope of practice/skills of the individual to whom care is delegated. The delegation can be to another RN, a licensed practical nurse or unlicensed assistive personnel. Follow-up guidance and supervision of care delegated is expected. In most states, activities that include the use of the nursing process or judgment/skills of the professional nurse (nursing assessment, diagnosis, plan of care, reassessment and evaluation of patient outcomes) can only be delegated to a registered nurse.

Charge nurses need to become familiar with the practice acts in their own states. In addition to specific guidance about supervision and responsibilities, nurse practice acts outline the scope of practice of nursing team members. Prior to delegating care in a healthcare agency, key agency policies such as the assignment of nursing care and administration of medications should be reviewed. Healthcare agencies also have position descriptions for each role that provide guidance for charge nurses about the expected competencies and role responsibilities of team members. Charge nurses are then ready to begin the delegation and supervision process which should include the following steps and reflective questions (NCSBN, 2005):

**Step One – Assessment and Planning**

**Goal – the Right Task, Under the Right Circumstances to the Right Person**

- What are the needs and condition of the patient?
- What level of clinical decision making and assessment is needed?
- What is the predictability of the patient’s response to care?
- What is the potential for adverse outcomes associated with the performance of tasks and functions?
- What are the cognitive and technical abilities needed to perform the activity/function/task?
- Which team member has the scope of practice, skills, competencies and experience to perform the tasks needed?
- What is the context of the situation and the environment — was the patient just admitted or did they have recent surgery, is it a high acuity environment such as an intensive care unit or ER?
- What level of interaction/communication is needed in the care of the patient and with whom?

**Step Two – Communication**

**Goal – the Right Direction**

- How is the task to be accomplished?
- When and what information is to be reported?
- What is the process for seeking clarification about delegated care?
- What are the communication expectations in emergency situations?

**Step Three – Supervision and Surveillance**

**Goal – the Right Supervision**

- What level of supervision and observation does the charge nurse need to provide?
- What will be the frequency of monitoring and observing care?
- How will the completion of care be verified and documented?
- How will unexpected changes in a patient’s condition be managed?

**Step Four – Observation and Feedback**

**Goal – Assessment of the Effectiveness of Delegation**

- Was the delegation successful?
- Is there a better way to meet the needs of the patient?
- Is there a need to adjust the plan of care?
- Were there learning moments for staff or charge nurse?
• Was appropriate feedback and follow-up provided by the charge nurse?
• Was positive feedback given when appropriate by the charge nurse?

In their discussion of the qualities of an effective charge nurse, Leary and Allen (2006) have noted that there is both an art and science to delegation. The science of delegation involves understanding licensure responsibilities from a legal standpoint and the policies of agencies where nurses work. The art of delegation involves effective communication with members of the healthcare team.

**Communicating Effectively**

Charge nurses engage in both horizontal and vertical communication at the unit level. They are seen as the pivotal point person, or ‘go to’ person. They must master the art of assertive and persuasive communication, as well as develop negotiation and listening skills. Conversations may be initiated by staff, patients, families, physicians, hospital leadership, or by the charge nurses themselves. Information is gathered and processed. Communication outcomes often result in changes in patient treatments plans, transfers to other levels of care, or in facilitating interdisciplinary communication with physicians or other departments. The success of the charge nurse’s communication efforts is often reflected in staff, patient, and physician satisfaction scores. They are frequently the first stop for any complaint. Charge nurses must also be familiar with the unique communication issues, styles, and preferences related to gender, generation, and cultural dynamics. Additionally, charge nurses must overcome the many distractions which create barriers to communication that prevent them from advocating effectively on behalf of the patients and staff.

Effective communication is essential for the reduction of medical errors and promotion of safety practices. Structured techniques which permit assertive clarification of team communication and avoidance of errors can be promoted and role modeled by the charge nurse. Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) is an evidence-based communication model that has been developed for use in clinical practice with funding from the Agency for Healthcare Research and Quality. Tools in the model include the Two-Challenge Rule, Call-Outs, and Check-Backs (AHRQ).

• The **Two-Challenge Rule** requires the communicator to voice their concern at least twice to receive acknowledgment by the receiver. This rule may be invoked when a member of the healthcare team suggests or performs an intervention that deviates from the standard of care. The charge nurse would assertively voice their concern at least two times and if the team member who is being challenged does not acknowledge this concern, the charge nurse would then take a stronger action or utilize the hospital chain of command as needed.

• **Call-Outs** are a strategy that the charge nurse can use to inform all team members of crucial information during emergencies to assist team members in anticipating what comes next. For instance, during a stroke alert, the results of the patient’s NIH scale and the need to transport the patient as rapidly as possible for a CT scan may be communicated out loud to the rest of the team.

• **Check-Back’s** require the sender of the communication to verify the information that is being received by the other team member, or to use closed-loop communication. For example, the charge nurse is often responsible for verifying that telephone order readbacks are performed according to policy.

Some communication takes place during times of escalating stress, such as in a rapid response event. Here effective and efficient communication is crucial for successful patient outcomes. Charge nurses can model and demonstrate evidenced based practice by utilizing recognized communication tools such as SBAR (Situation-Background-Assessment-Recommendation) (Institute of Healthcare Improvement). Communication handoffs that promote a shared mental model regarding the patient’s unique condition are essential (Haig, Sutton, & Whittington, 2006). A shared mental model is the understanding about the current patient situation that is shared among the team (AHRQ). If the team is communicating well, then responses to patient needs will be quicker and deaths due to ‘failure to rescue’ will be avoided. Staff nurses must be able to trust in the charge nurses ability to assist them to respond to a sudden change in a patient’s condition. Skilled communication at the unit level is viewed as one measure to balance a culture of safety with the workforce challenges that exist in the current healthcare environment (Hinshaw, 2008). When there are communication difficulties at the unit level, it can lead to the development of conflict between one or more team members.

**Managing Conflict**

Casey Stengel, the beloved manager of many major league baseball teams, once noted that “Finding good players is easy. Getting them to play as a team is another story” (Stengel). The same could be said of teams in healthcare settings. Communication breakdowns and conflict are inevitable on teams. The results of recent research indicate that few members of healthcare teams are com-
fortable having the type of crucial conversations that teams need to have when there is conflict or poor performance (Vital Signs, 2005).

Guiding team members past their day to day problems, conflicts and communication issues to work together as a team can be challenging for charge nurses. If conflict is managed effectively, it can be viewed as an opportunity for team growth. The necessity of effectively managing team conflict should be framed in terms of a patient safety issue. Root cause analysis studies done by the Joint Commission on Accreditation of Healthcare Organizations since 1995 indicate that a breakdown in communication among caregivers is the top contributor to sentinel events (JCAHO, 2008).

Conflict between team members usually evolves from differences in experiences, attitudes, behaviors, and work values. Left unresolved, conflict can cause a loss of productive work time, medical errors, decreased patient satisfaction, and staff turnover (Manion, 2005). Open discussion with staff about differences in attitudes and values is an important first step. Staff may not be willing to consider other viewpoints as legitimate unless they are required to participate in conflict resolution.

The following steps in the conflict resolution process can be used to help staff discuss and mediate conflict that involves differences (Moss, 2005):

1. Agree to ground rules for discussion that are acceptable to all parties.
2. Allow each person to tell their story from their perspective.
3. Highlight an overall goal that all team members value — example — providing the best care possible to our patients.
4. Develop interventions collaboratively and agree to disagree on points of contention.
5. Keep the lines of communication open and respect differences in attitudes, values and behaviors.

The charge nurse’s overall goal in the mediation of conflict should be to help team members work more effectively together to meet the needs of patients.

**Building Team Synergy**

Charge nurses play a crucial role in the retention and turnover of registered nurses. As team leaders, they set the tone for unit performance by creating a culture which promotes staff effectiveness and productivity, with the goal of coordinating all components of patient care. The charge nurse is at the core of everything happening on the unit. With increasing patient acuity and shortened lengths of stay, charge nurses are the essential drivers of positive patient outcomes. In environments where staff work 12-hour shifts, they are often the only stable force as the other team members are fluid and always changing. Whereas the staff nurse is cued in to their individual patient assignment and isolated tasks, the charge nurse must maintain a more global systems perspective. Charge nurses anticipate the need for crisis intervention, respond to unique individual circumstances, maintain quality standards, and coordinate patient care. Charge nurses can encourage team collaboration and promote the use of interdisciplinary patient rounds. More effective teamwork and coordinated patient handoffs are critical to the promotion of a safe patient care environment (Edwards, 2008; Schmalenberg & Kramer, 2009; Shortell & Singer, 2008).

The TeamSTEPPS (AHRQ) model for high functioning teams includes principles from the Crew Resource Management Model (CRM) which originated in the aviation industry (Kosnik, Brown & Maund, 2007). The CRM model is designed to promote effective team management with a goal of addressing errors in ‘dynamic environments’ that could be caused by ineffective communication in independent processes. The charge nurse role is uniquely positioned to guide the team in the use of these strategies. In healthcare, the entire team is responsible for the patient. Charge nurses are at the front lines of patient care, and remain accessible to the staff while facilitating and overseeing the multitude of human interactions which take place in a typical patient care day. As a result, they can provide strong team leadership. This is essential to inspire a clear, shared vision, and to build the necessary trust and confidence necessary to optimize patient and productivity outcomes. Team members who clearly understand their roles and responsibilities can then be proactive, rather than reactive. Effective charge nurses actually create the climate that allows teamwork to happen.

The TeamSTEPPS model emphasizes that the charge nurse, as the team leader, must remain both situationally aware and cognizant of the current conditions which may be impacting the work of the team (AHRQ). **Briefings** are encouraged at the beginning of the shift to plan for patient care, **huddles** can occur on an as needed basis to problem solve, and timely conflict resolution is recommended. Team members can then assist each other with tasks and provide effective feedback. The charge nurse can then lead **debriefings** in order to provide crucial feedback after intense patient events, or at the end of the shift. This process promotes performance improvement and encourages all members of the team to learn and grow.

Staff members need to feel valued and essential to unit function. Many times nurses go without needed breaks. If nurses are not supported in caring for self, this leads to low
staff morale. The charge nurses can assist with seeing that these breaks are taken and heavy workloads are redistributed. An additional stressor is when staff nurses precept or orientees or novice nurses. When making assignments, the orientation for new staff must be adjusted for and supported. Although this type of knowledge may not have been formally discussed in their education or training, charge nurses must ensure that the orientation period is adjusted to meet the unique needs of each individual nurse. Leadership attributes of charge nurses should include motivating and inspiring collaboration among team members. Every effort must be made to ensure that adequate resources of staff, supplies, information, and feedback are present. Charge nurses also model promoting the mission and vision of the organization for the team members. Effective leadership by charge nurses at the unit level can then create working conditions which empower the nurses and foster their commitment to the organization (Spence Laschinger, Finegan, & Wilk, 2009).

**Summary**

Charge nurses play a key role in providing leadership at the point of care on their units. Developing the skills to effectively supervise and delegate, communicate, resolve conflict and build strong team synergy are important success factors. The charge nurse role can be compared to air traffic controllers in the aviation industry. On today's busy and often chaotic patient care units, patients, staff and interdisciplinary team members rely heavily on charge nurses for their guidance and direction. Rising to meet this leadership challenge can provide enormous professional satisfaction and a tremendous leadership growth experience.

**References**


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Terry Eggenberger is an Instructor on the faculty of the Christine E. Lynn College of Nursing at Florida Atlantic University where she is also completing her doctoral studies with a research emphasis on the charge nurse role.
Healthcare organizations and providers throughout the country are seeking to implement an effective and financially efficient process to address conflict within the workplace. The desire to provide staff with conflict education has gained momentum as the connections between patient safety and the healthy work environments are increasingly more apparent. Adding to the impetus are the addition of the 2009 Joint Commission new leadership standards and Sentinel Event Alert #40 which outlined the requirements for such processes and education (Scott, 2009). The purpose of this article is to present potential considerations when selecting and evaluating conflict training programs for healthcare organizations and providers.

**Program Content**

Learning to handle conflict is a skill that requires knowledge and practice to allow for maximum integration within the daily communication styles of the participants. It is similar to learning a new clinical skill. For example, when nursing students first learn the skills of IV catheter insertion, they learn the anatomy and physiology of the procedure and the parts of the equipment. Later, the students practice in a simulation lab to facilitate the transfer of new knowledge to a more realistic setting. With practice, the student develops proficiency.

Developing the skills of managing conflict follows a similar process. First, one should gain the knowledge, then practice the new skills by integrating them in simulated real-life settings with skills-based training and coaching. Any course considered for conflict education should encompass both the content and the practice needed to embed these new skills.

The most effective programs will utilize case-based scenarios when describing the content so that staff may be able to more easily apply content within to their own settings. Further, the use of reflective exercises as part of the training component will allow participants to practice the communication skills such as listening, acknowledging, empathizing and clarifying. Participants should be able to learn to use reflective practice skills and scenarios that are intended to increase their ability to respond to others as well as increase their own self-awareness of their own behaviors (McGuire, Inflow, 2005).

**Trainers and faculty**

Trainers and faculty optimally should have the necessary knowledge of conflict and be able to clearly identify with current healthcare culture. Perhaps more importantly, the best conflict programs should have trainers who are able to facilitate and coach interactive skills-based exercises and be able to provide meaningful feedback to the participants.
These coaches should have been specifically trained at role-playing, reflective practice and other situational learning methods.

**Customized approach**

Optimal training programs recognize the diversity of experience of the participants as well as the context by which training is to be delivered (Schoenhaus, 2001). Programs should be adaptable with simulations that are student centered while recognizing the unique situations and climates inherent to every organization. When assessing this area of a conflict program, it is important that the curriculum demonstrate clear adaptability while maintaining evidence-based theories grounded in best practices within the field of conflict.

**Financial considerations**

For many organizations, the current economic downturn and future uncertain effects of healthcare reform have presented formidable challenges for the selection and implementation of substantive training programs. While many programs in the past would provide team building and inspirational messages to providers, leaders are now more selective and are choosing training programs that affect the system, not just the individual, to garnish the greatest results (Ulrich and Smallwood, 2009).

In short, if the training provides measurable results at a system level, there will be a greater return on investment and the increase in the likelihood of financial approval from senior administrators.

**Logistical outreach**

For long-term culture change and maximum impact, conflict education needs to reach as many members of an organization as possible. However, the logistics of training healthcare providers can be formidable. As healthcare organizations operate on a 24/7 basis convening basic staff meetings is difficult and system-wide education can be a monumental task. In addition, the expense of training facilities and the provision of patient care while staff are attending programs can be cost prohibitive and difficult logistically.

However, when all employees hear the same message and learn similar skills, they have a template for future accountabilities. Everyone will know the parameters of acceptable behaviors, and more importantly, improved responses when witnessing conflict. Thus, when selecting a program for conflict management, consider programs offered though a variety of methods to accommodate all staff, regardless of the shift or hours in which they work.

Alternative solutions, including online education or webinars accessible through the Internet, can present information while laying the groundwork for future development or training.

Any program under consideration also should contain continuing education credit as a value added incentive. Even if continuing education is not mandated for the renewal of a state licensure, many licensed staff require credits for certification and specialty degrees.

**Conclusion**

Learning the skills of conflict engagement can provide great short and long term benefits to the enhancement of healthy work environments. For programs to have significant impact they must contain specific content and evidence-based training practice for healthcare providers to enhance their new skills. Faculty should be trained in reflective practice and dispute resolution and be clearly aware of the current types of experiences present within the specific organization. System-level conflict courses can provide the template for safer, more effective patient care and improve work environments for the people who care for them.

**About the Author**

Diane E. Scott, RN, MSN is a Program Director for the Center for American Nurses. She can be reached at diane.scott@centerforamericannurses.org

**References**


Dear Confused,

It can be disheartening when the career you’ve wanted for as long as you can remember turns out to be less than satisfying. The good news is that there are many different career choices for nurses, and with a little reflection and effort on your part, the chances are high that you can re-energize your nursing career.

First, take time to reflect on these questions:

• What have you felt most engaged in during your work as a nurse?

• What are your particular strengths?

Your responses to these questions will give you your first clues about potential career options for you.

Next, think about other things that are important to you as you consider a career transition. Think about salary and benefits, location, autonomy, work setting, schedule, and anything else that will impact your job satisfaction.

Armed with all of this information, you can research potential careers and then conduct informational interviews with people who have positions that are interesting to you. Not only will you learn about what the job is really like, you’ll learn about the educational and experience requirements for each position.

Once you’ve completed your research, it’s time to craft a transition plan. Do you need to go back to school for an advanced degree or specialized training? Do you need to reach out to your network to help with your search? How will you approach your job search?

Here are some resources that may make your transition easier:

• www.centerforamericannursescoaching.org/Articles_and_Resources.html

• www.nurse.com

• www.nurseconnect.com

• www.discovernursing.com

The ULTIMATE Career Guide For Nurses: Practical Strategies for Thriving at Every State of Your Career, by Donna Cardillo, RN, M.A.

It’s not easy to make a career change, but it is possible. Good luck!

The Center for American Nurses Career Coaching Team

Dear Career Coach,

I currently work as a med-surg nurse for a large regional hospital. It’s a great place to work, but over the past few years, I’ve enjoyed my job less and less. Although the only career I’ve ever even considered is nursing, I’m beginning to question whether I should stay in the profession.

Confused
The path to career satisfaction is personal.

The Center for American Nurses is proud to bring you a coaching program designed to connect registered nurses with professional coaches specializing in the diverse aspects of a nursing career.

A professional coach can help you:

• **Evaluate your career choices** through the lens of your strengths, values, and long-term personal and professional goals.

• Look at the way your current choices impact your **work-life balance** and identify the changes that will have the biggest impact on your personal and professional satisfaction.

• **Develop more confidence**, create strategies to improve your visibility and promote-ability and give you a safe place to practice critical conversations.

• **Objectively assess your leadership, communication, or conflict skills** and provide you with tools you can use immediately to increase your emotional intelligence and become more effective both personally and professionally.

• Identify strategies to deal with a **difficult situation at work**.

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**Career and Work-Life Balance Tele-Seminars**

Tele-seminars, led by members of the Center’s coaching team, are available. Topics range from How to Deal with Layoffs to Strategies for Managing Fatigue. Program materials are provided for each tele-seminar. To register go to www.CenterforAmericanNursesCoaching.org
National Experts on Conflict and Healthcare Design Highlight LEAD Summit 2009

By Diane E. Scott, RN, MSN

The Center for American Nurses’ third Annual Leadership, Education, Advocacy and Development (LEAD) Summit 2009, was held June 11 through June 13 at Disney’s Contemporary Resort in Orlando, Florida.

The title of the Summit, The Magic of Engagement, initiated the theme of conflict resolution strategies as healthcare providers were given the means to address and minimize conflict within healthcare. “The topics presented around conflict engagement provided me with practical and relevant tools that I can use in my work,” said Carol Stevens, MS, RN, Associate Director, Academy for Continuing Education at Arizona State University.

As a primary contributor for the Center for American Nurses Conflict Engagement portfolio, Debra Gerardi, RN, MPH, JD presented several sessions, including a pre-conference titled, “Skills for Conflict-Competent Nurses: Moving from Avoidance to Engagement.” Within her sessions, she spoke of the nurse’s role in conflict as well as describing successful strategies to engage in the conversations that are critical for healthy work environments.

Ms. Gerardi also is the primary contributor for the Joint Commission Sentinel Event Alert Issue 40, Behaviors that Undermine a Culture of Safety. During the Summit, she presented the implications for healthcare providers and leaders for this alert as well as the new leadership standards effective January 2009. Specific to her content was the description of required training for healthcare leaders needed to obtain competency in identifying and resolving conflict.

Dr. Phyllis Beck Kritek opened the plenary session with an address titled, “The Magic of Creative Conflict Engagement.” Dr. Kritek is nationally recognized for her training in conflict engagement skills and is a Kellogg National Leadership Fellow. In her informative session, she discussed the contrast of relationship-based conflict engagement to existing patterns of conflict that are detrimental to the profession of nursing.

As one of the primary national nursing organizations to address healthcare design and nursing, the Center for American Nurses brought to this year’s LEAD Summit some of the nation’s top nursing design experts. Dr. Jan Stickler, RN, FAAN, Associate Professor of Nursing at San Diego State University and co-editor of Health Environments Research and Design (HERD), articulated ways that nurses can participate in healthcare design and construction to improve their work environment. Her co-presenter, Deborah Gregory, RN, BSN, co-founder of the Nursing Institute for Healthcare Design, discussed the influence of nursing on healthcare design as a means for healthier work environments for patients and the nurses who care for them.

“The LEAD Summit was the perfect forum for nurse leaders to gain a valuable edge. If we are going to truly improve healthcare, we must begin with an understanding of how to improve the planning, design, and construction of our hospitals.”

Ms. Derr presented an informative session describing the nurse’s role in construction including environmental concerns as well as cost containments.

Others speakers at the LEAD Summit included Dr. Beth Ulrich, RN, EdD, FACHE, FAAN, Senior Vice President of Business Analytics and Research for Versant. In her address, she spoke of the initiative for nurses to control and create their own positive work environments. This initiative allows nurses to become engaged in ensuring safe environments for each other and their patients.
During the entire LEAD Summit, attendees remarked at the caliber of the presentations. “Given the quality and reputation of the speakers at previous LEAD Summits, I am pleased that we did not disappoint our attendees as our speakers once again provided rich and detailed informative sessions in the areas of Conflict and Healthcare Design,” said Dennis Sherrod, President of the Center for American Nurses.

Ed Suddath, Executive Director for the Maryland Nurses Association said, “I felt that the LEAD Summit provided the attendees with valuable tools and techniques that they could apply to their work environments.”

**About the Author**

*Diane E. Scott, RN, MSN,* is the Program Director for the Center for American Nurses, Conflict Engagement Program which offers an unprecedented approach at helping organizations and individuals learn the skills of successful conflict engagement. She can be reached at dianescott@centerforamericannurses.org.

Missed the LEAD Summit or want to learn more about the Center’s information on Conflict Engagement and other programs? Please visit the Center’s website at www.centerforamericannurses.org.
Walt Disney World’s Magic Kingdom offered the perfect setting as nurses from across the country gathered in Orlando, Florida for LEAD Summit 2009, The Magic of Engagement.

“OUR SPEAKERS ONCE AGAIN PROVIDED RICH AND DETAILED INFORMATIVE SESSIONS,” SAID DENNIS SHERROD, PRESIDENT, CENTER FOR AMERICAN NURSES

Debra Gerardi (left) and Phyllis Beck Kritek (right, joined by Dennis Sherrod) shared creative strategies for addressing conflict in the workplace.
Exploring the Magic of Creative Conflict Engagement.
Patti Digh, author of *Life is a Verb* helped workshop participants to seek the magic with themselves.

“The topics around conflict engagement provided me with practical and relevant tools that I can use in my work,” said Carol Stevens, MS, RN, Associate Director for Continuing Education Arizona State University.
Beth Ulrich, challenged participants to create healthy work environments during her session, Creating Magic: Engaging and Being Engaged.

“I felt that the LEAD Summit provided the attendees with valuable tools and techniques that they could apply to their work environments,” said Ed Suddath, Executive Director for the Maryland Nurses Association.

Rebecca Patton, ANA President joins Dennis Sherrod and LEAD Summit participants.
The North Carolina Nurses Association (NCNA) recently named seven nursing workplaces as Hallmarks of Healthy Workplaces recipients: Randolph Hospital, Carolinas Medical Center’s Infusion Center, Carolinas Medical Center — University’s Intensive Care/Progressive Care Unit (ICU/PCU), and Carolinas Medical Center — Mercy’s Kidney Dialysis Unit (KDU) and Surgical Intensive Care Unit (SICU). These exceptional workplaces were recognized for creating positive work environments for registered nurses. Duke Raleigh Hospital and the James E. Davis Ambulatory Surgical Center successfully renewed their Hallmarks status. The awards will be presented at an August 7 ceremony.

“The NCNA Hallmarks of Healthy Workplaces award means a lot to our staff,” said Tremonteo Crawford, Randolph Hospital’s Chief Nurse Officer. “This award is driven by our staff and is about our outstanding staff. It is an indication of the positive work environment that they create. I feel very privileged to lead nurses that take ownership and accountability for creating a caring environment that extends to our patients, families, and our colleagues. I am proud of the nurses at Randolph Hospital.”

The Hallmarks of Healthy Workplaces program recognizes and promotes positive workplaces for nurses within North Carolina and aids healthcare providers in creating workplaces in which communication flows freely and nurses contribute actively to facility governance. The program was created by NCNA in an effort to address the state’s nursing shortage through recognition. Hallmarks operates with the understanding that nurses who provide care in exceptional environments promote the highest quality of care to their consumers.

“We are delighted that Duke Raleigh Hospital has been re-designated as a North Carolina Hallmarks of a Healthy Workplaces Hospital,” said Rosemary Brown, Duke Raleigh’s Chief Nurse Officer. “Since our initial award in 2006 we have continued to strive for a work environment that supports our nursing staff with the resources necessary so that they can provide extraordinary care. Our 2009 application and on-site survey confirmed that our nursing staff report high satisfaction with the organizations support in the areas of leadership, professional development, empowerment, safety and quality.”

The recognition program grew from a four year process that included a literature review, focus groups on issues related to the nursing shortage, and comparison of Hallmarks criteria with recognition criteria from other associations. Any workplace in which three or more registered nurses are employed or volunteer is eligible to apply. This includes hospitals, units within hospitals, schools of nursing, outpatient clinics, private practices, home health settings, prisons, hospices, and more.

Initial funding for the program was provided by the Center for American Nurses, the North Carolina Foundation for Nursing, the North Carolina Organization of Nursing Leaders, the Nursing Spectrum-Gannett Foundation, High Point Regional Health System and a grant from The Duke Endowment. The Hallmarks program is endorsed by several organizations, including the North Carolina Hospital Association, North Carolina Medical Society, AARP of North Carolina, North Carolina Organization of Nurse Leaders, and the Association for Home & Hospice Care of North Carolina.

Hallmarks Recognition is based on three basic criteria: support of nursing professional development, system support for nurses to provide quality service, and integration of nursing into operations and governance. Applicants complete an anonymous online nurse satisfaction survey, written application, and an on-site survey. A team of three trained reviewers is assigned to each applicant. The team reviews orientation policies, preceptor training manuals, meeting minutes, policies and additional supporting documentation.

Previous recipients include Carolinas Medical Center’s Cardiac Catheterization Lab, Carolinas Medical Center — University’s Endoscopy/Special Procedures Unit, Maternity Center, and Surgical/Pediatrics Unit, and Duke University Medical Center’s Cardiac Intensive Care Unit, Durham Regional Hospital’s Post Anesthesia Care Unit (PACU) and Endoscopy Services Unit, FirstHealth School Nurse Program, Halifax Regional Medical Center, and the Highsmith Rainey Intensive Care Unit.

For more information, please visit www.hallmarks.ncnurses.org or contact Ashley Trantham at 800-626-2153 or hallmarks@ncnurses.org.

About the Author
Ashley Trantham is the Director of Hallmarks Administration & Development at the North Carolina Nurses Association.
10 Ways of Implementing Current Design Concepts in Your Workplace

Healthcare environments have significant effects on the health and safety of patients and staff, efficiency of care, and staff effectiveness and morale (Robert Wood Johnson Foundation, 2004).

Evidence shows that a well-planned facility design can improve the quality of care for patients, promote recruiting and retention of staff, and enhance operational efficiency and productivity (The Center for Health Design, 2007). Improved workplaces can lead to healthier environments; this promotes the well-being and safety of healthcare workers and patients.

Listed below are 10 ways of implementing current design concepts in your workplace.

1. **Become a knowledgeable change agent.**
   - Educate yourself on current trends in design and sustainability.
   - Offer open forums at which staff members and leaders can voice their ideas.
   - Identify champions among hospital staff who are knowledgeable and interested in design and environmental advocacy; invite them to serve on committees and task forces.

2. **Assemble a design steering committee.**
   - Ensure that this committee consists of formal and informal leaders.
   - Include infection control nurse specialists, physicians, and representatives from all shifts.
   - Develop ground rules to encourage collaboration and active participation.
   - Present a vision and a mission to the committee to ensure that efforts are geared toward consideration of quality and safety.

3. **Promote effective communication within the committee.**
   - Focus on finding and achieving desirable outcomes.
   - Seek to advance collaborative relationships among leaders and nursing colleagues.
   - Invite and hear all relevant perspectives.
   - Call upon good will and mutual respect to build a consensus and arrive at a common understanding.

4. **Develop and implement a process by which you and other nurses can learn about evidence-based design and sustainability.**
   - Disseminate information about healthcare design obtained from current literature and related websites.
     - Attend relevant conferences and seminars regarding healthcare design and environmental sustainability.
     - From the outset, include staff from other disciplines in the process.
     - Include facilities department staff and infection control specialists.
     - Invite nurse specialists and architects from architecture firms to provide educational programs.
     - Prior to project execution, review phases of design and construction with an expert in the design process. Address occupancy planning and move-in logistics, as these are often forgotten.
5. Assess the workflow process.
   • Walk through existing operations, and create a map that will serve as a guide to desired changes in operations.
   • Ensure that the processes drive the design, not vice versa.
   • Address both clinical and operational processes.

6. Conduct an assessment of how planned design concepts are being implemented within your healthcare organization.
   • Identify priorities for change and improvement.
   • Develop an action plan that will allow analysis of results.
   • Before deciding on a design process, identify evaluation criteria that can be used to assess variables before and after implementation; these will provide a means of demonstrating the success of the project.

7. Conduct site visits to healthcare organizations and set up interviews with staff members who have successfully implemented similar design concepts.
   • Prior to planning a site visit, invest in learning about best practices and evidence-based design.
   • Site visitation teams should include staff nurses, nursing leaders, physicians, auxiliary staff members, administrative leaders, and at least one design professional.
   • Ideally, site teams should be interdisciplinary; consider including a patient or a family member who has experience with the hospital.
   • Include staff from all shifts.
   • Ask permission (ahead of time) to take pictures.
   • Develop a list of questions that will guide your site visit. Include questions on process and design. Note signage that guides a visitor’s way, visual appeal of the unit, noise levels, lighting, and spaces for staff and families. Assess rooms for appropriateness of location; note adjacencies and amount of space devoted to layout and function.

8. Ensure ongoing feedback and reflection.
   • Allow interdisciplinary team members who attended site visits to make presentations to staff and leaders who did not participate and to reflect on findings.
   • Offer opportunities for staff and leaders to share their own personal and professional stories about healthcare design experiences.
   • Create “mock-up” rooms, in which a proposed design is laid out in an empty space. Lay out tape for marking walls; set up beds, gurneys, and real equipment; and give staff a chance to test-drive the proposed setup.
   • Plan for realistic space and program needs—not just for the maximum number of beds required for future growth. Ask finance department staff to provide bed number projections.
   • Develop an action plan that incorporates agreed upon concepts and tactics, and assign responsibilities.
   • Select an architect and an interior designer who are knowledgeable about evidence-based design and environmental sustainability.
   • Candidates should be experienced with similar projects, must exhibit a willingness to listen and to respond to needs, and should respect differing perspectives; they must be able to process information and translate it into design concepts. Candidates should also be knowledgeable about evidence-based design and environmental sustainability and must work well with nurse specialists who will serve as advisors.
   • Look into other healthcare organizations that have worked on similar projects, and obtain candidate references from their senior leadership.

10. Communicate your findings and plans with appropriate leaders to obtain buy-in and direction.
   • Develop a one-page briefing/executive summary that highlights what you are trying to achieve.
   • Send the briefing to hospital leaders in advance, to allow ample time for review before the meeting date arrives.
   • Plan and coordinate a meeting with key leaders.

References
Also see www.rfw.org/files/publications/other/wisdomat work.pdf.
Get It Together! Financial and Health Care Paperwork You Need Right Now

WISERWoman

So here’s a plan—while it’s still tax season, why not take some time and get organized one step further? Instead of just gathering up your important paperwork, make sure that you actually have all the documents you need. The easy stuff first: finding your Social Security card, birth and marriage certificates or divorce settlement papers. Then there are the titles to the car and the house.

More importantly, many of us have no idea where our Health Care Power of Attorney is—if we even have one. That’s because most people avoid the issues that are hardest to think about. Resolve to organize your important paperwork in one place.

Don’t be overwhelmed, just get started, and then enjoy the peace of mind that comes with knowing you have taken action.

As a first step, find one place to keep your important documents and make sure your family knows where it is. In a time of crisis, will your children know what insurance you have or what your health care wishes are? What if you were in an automobile accident and were unable to communicate? Have you identified the person you would like to have making your financial or health care decisions? Or what if you actually died as a result of your injuries? Would your family members know that you had a 401(k) with your former employer?

Advanced planning for life’s important decisions is as necessary as living your life. You need to make your wishes known to the people who can carry them out if you are unable to do so. And this requires a little planning. We also strongly suggest that you review everything with a lawyer or other expert in financial and estate planning.

Here are three basic financial documents that everyone needs:

- Durable Power of Attorney for Finances
- Living Trust, and
- Last Will and Testament

It is also important that you have health care documents called Advance Directives. These are:

- Health Care Proxy (also called a Durable Medical Power of Attorney)
- Living Will

Financial Documents:

1) **Durable Power of Attorney for Finances** is a legal document in which you appoint another person to act on your behalf. This keeps your finances in the hands of a person you trust. If you become incapacitated, that person has the authority to make financial decisions for you. The Durable Power of Attorney may be used immediately and is effective until you die or until you decide to revoke it. This person must act in your best interests, keep accurate records, keep your property separate from his or hers and avoid conflicts of interest.

2) **Living Trust** (not a living will) is a legal document that allows you, or a person you name as trustee, to transfer ownership or title to your assets into a trust, but still have control of those assets throughout your lifetime. It names those who are to receive the assets from your trust when you die. A living trust allows your heirs to avoid probate.

3) **Last Will and Testament** is a legal document that gives directions about where and to whom your assets should go after you die. You name an “executor” to carry out your directions as stated in the will. Consider someone in whom you have complete confidence, who is well organized, someone who knows you, but does not have a conflict of interest. What is considered a valid will varies from state to state; therefore we strongly recommend that you ask an attorney who specializes in estate law to at least review your will.
So how do you choose the trustee for your living trust and the executor for your will?

**Trustee.** Some people name themselves as trustee so they can manage their trust unless they become incapacitated or die. Or they appoint a successor trustee if they become unable or unwilling to act. Or they appoint co-trustees. Others name an institution as trustee. If you name a trustee, remember that this person will have control of your assets, so choose carefully—someone responsible and reliable. You might decide on a family member, a child, a business associate or a financial advisor.

**Executor.** Your executor is the person (or institution) you name in your will to manage your estate and carry out your wishes after your death. An executor, unlike a trustee, is “under the supervision of the court,” and must obey the state laws.

Being named executor may or may not be considered a compliment and it can be considered a burden. Consider someone in whom you have complete confidence, who is well organized, someone who knows you, but does not have a conflict of interest — someone who has the personal maturity to do what has to be done. As is the case with trustees, you can appoint co-executors. You may make a provision to pay your executor.

Your executor and your trustee can be the same person or institution.

**NOTE:** There are lots of people who want to sell you their services. Be wary of “free” estate planning seminars whose business purpose is to sell legal and financial services.

**Health Care Documents — Advance Directives:**

You will need two documents: a Health Care Proxy and a Living Will.

It is advisable to have both documents. The person with your Health Care Proxy or Power of Attorney is designated to make decisions, based on your instructions, if and when you are unable to speak for yourself. While a Living Will specifically outlines your decisions about health care treatment, it does not provide a spokesperson. Together, a health care proxy and a living will can work to make your health care wishes clear and guarantee those wishes are carried out.

1) A Health Care Proxy, also called a Health Care Power of Attorney or Durable Medical Power of Attorney, is a person you appoint to make health care decisions for you if you are unable to make those decisions for yourself. A health care proxy can make sure that health care providers follow your wishes and can decide how your wishes apply as your medical condition changes. Hospitals, doctors and other health care providers must follow this person’s decisions as if they were your own.

You may give this person as little or as much authority as you want, i.e. you may allow your proxy to make all your health care decisions or only certain ones. Whoever it is, be sure it is someone you trust to carry out your wishes. You should also consider naming a proxy who lives close to you. If you are terminally ill and unable to make decisions, your proxy might have to spend a great deal of time nearby to see that your wishes are followed.
2) A Living Will serves as a written declaration of your health care wishes when you cannot communicate them personally. It explains your health care preferences and instructs your doctor about your end-of-life decisions. You may say something as simple as, “I prefer that all care be directed at comfort and that life-supportive treatments not be used.” Or, you may want to be more precise and describe the medical situations in which you would accept or refuse medical treatment. For example, a do not resuscitate order (DNR) makes clear that you do not wish to have cardiopulmonary resuscitation (CPR) to restart your heart and lungs.

(NOTE: A Living Will is not used to name a proxy. You must name your proxy in a separate document — see Health Care Proxy above.)

Writing a Living Will:

Make sure:

- The statement of your personal health care wishes is clear.
- Your name is clearly defined as the person creating the Living Will.
- You have signed and dated the document.
- Two witnesses sign and date the document.
- The witnesses make short statements that you signed the document willingly.
- You have the Living Will notarized as a safeguard.

After preparing and signing the documents:

- Make copies of the completed documents.
- Keep the originals in a safe place.
- Give copies to your proxy, your attorney or other advisor, close family members, your doctor and anyone else involved in your health care.

Remember both the Health Care Proxy and Living Will:

- Help to insure that your health care wishes are followed if you are unable to speak for yourself;
- Can be cancelled by you at any time;
- Should be discussed with close friends or family members. You may also wish to consult with a professional for assistance

Resources:

There are numerous sites online with easy to fill in forms and advice. Some require payment and others are free. You will find some examples at the following:

www.legalzoom.com
www.TheTrustguide.com
www.caringinfo.org
Supporting Family Caregivers in Providing Care

BY SUSAN C. REINHARD, BARBARA GIVEN, NIRVANA HUHTALA PETLICK, ANN BEMIS

The Agency for Healthcare Research and Quality (AHRQ) recently published a new book, Patient Safety and Quality: An Evidence-Based Handbook for Nurses. (AHRQ Publication No. 08-0043). This comprehensive 1400 page handbook for nurses provides valuable information for nurses on patient safety and quality, evidence-based practice, patient centered care, working conditions, and work environment for nurses. The following article is an excerpt from Chapter 14 of this handbook. The complete book is available online at www.ahrq.gov/qual/nurseshdbk.

Background

Most patients have families that are providing some level of care and support. In the case of older adults and people with chronic disabilities of all ages, this “informal care” can be substantial in scope, intensity, and duration. Family caregiving raises safety issues in two ways that should concern nurses in all settings. First, caregivers are sometimes referred to as “secondary patients,” who need and deserve protection and guidance. Research supporting this caregiver-as-client perspective focuses on ways to protect family caregivers’ health and safety, because their caregiving demands place them at high risk for injury and adverse events. Second, family caregivers are unpaid providers who often need help to learn how to become competent, safe volunteer workers who can better protect their family members (i.e., the care recipients) from harm.

This chapter summarizes patient safety and quality evidence from both of these perspectives. The focus is on the adult caregiver who provides care and support primarily for adults with chronic illnesses and chronic health problems. The focus is not on those with developmental disabilities. In the first section, we discuss the evidence for protecting the caregiver from harm. The second section addresses research aimed at protecting the care recipient from an ill-prepared family caregiver.

Caregivers as Clients

For centuries, family members have provided care and support to each other during times of illness. What makes a family member a “family caregiver”? Who are these family caregivers, what do they do, and what harm do they face? What does the research tell us about ways to assess the needs of these hidden patients and evidence-based interventions to prevent or reduce potential injury and harm? This section answers these questions and highlights the need for nurses to proactively approach family caregivers as clients who need their support in their own right.

Description of Caregiver Population

The terms family caregiver and informal caregiver refer to an unpaid family member, friend, or neighbor who provides care to an individual who has an acute or chronic condition and needs assistance to manage a variety of tasks, from bathing, dressing, and taking medications to...
tube feeding and ventilator care. Recent surveys estimate there are 44 million caregivers over the age of 18 years (approximately one in every five adults).\textsuperscript{1} The economic value of their unpaid work has been estimated at $257 billion in 2000 dollars.\textsuperscript{2} Most caregivers are women who handle time-consuming and difficult tasks like personal care.\textsuperscript{3} But at least 40 percent of caregivers are men,\textsuperscript{3} a growing trend demonstrated by a 50 percent increase in male caregivers between 1984 and 1994.\textsuperscript{4} These male caregivers are becoming more involved in complex tasks like managing finances and arranging care, as well as direct assistance with more personal care.\textsuperscript{5} Nurses are likely to see many of these caregivers, although many of them will not identify themselves as a caregiver.

Those caring for someone 50 years or older are 47 years old—on average—and working at least part-time.\textsuperscript{1} If they are providing care to an elder who is 65 years or older, they are, on average, 63 years old themselves and caring for a spouse; one-third of these caregivers are in fair to poor health themselves.\textsuperscript{6} In many cases, they are alone in this work. About two out of three older care recipients get help from only one unpaid caregiver.\textsuperscript{7} In the last decade, the proportion of older persons with disabilities who rely solely on family care has increased dramatically—nearly two-thirds of older adults who need help get no help from formal sources.\textsuperscript{4}

Hazards of Caregiving

Health professionals’ lack of explicit attention to caregivers is a serious gap in health care in light of the more than two decades of research that documents the potential hazards of family caregiving. Caregivers are hidden patients themselves, with serious adverse physical and mental health consequences from their physically and emotionally demanding work as caregivers and reduced attention to their own health and health care.

Declines in physical health and premature death among caregivers in general have been reported.\textsuperscript{21, 25} Given and colleagues\textsuperscript{18, 19} and Kurtz and colleagues\textsuperscript{26} found that family caregivers experience significant negative physical consequences as the patient’s illness progresses. Elderly spouses who experience stressful caregiving demands have a 63 percent higher mortality rate than their noncaregiver age-peers.\textsuperscript{21} Most recently, research documents that elderly husbands and wives caring for spouses who have been hospitalized for serious illnesses face an increased risk of dying prematurely themselves.\textsuperscript{27}

Declines in caregiver health have been particularly associated with caregivers who perceive themselves as burdened.\textsuperscript{21} Caregiver burden and strain have been related to the caregiver’s own poor health status, increased health-risk behaviors (such as smoking), and higher use of prescription drugs.\textsuperscript{28} Researchers have reported that caregivers are at risk for fatigue and sleep disturbances,\textsuperscript{29} lower immune functioning,\textsuperscript{30, 31} altered response to influenza shots,\textsuperscript{32} slower wound healing,\textsuperscript{33} increased insulin levels and blood pressure,\textsuperscript{34, 35} altered lipid profiles,\textsuperscript{36} and higher risks for cardiovascular disease.\textsuperscript{37}

Caregiver burden and depressive symptoms are the most common negative outcomes of providing care for the elderly and chronically ill.\textsuperscript{20, 25, 56} Caregiver burden is defined as the negative reaction to the impact of providing care on the caregiver’s social, occupational, and personal roles\textsuperscript{57} and appears to be a precursor to depressive symptoms.\textsuperscript{28} Whether the caregiver develops negative outcomes seems to be directly related to the care recipient’s inability to perform ADLs, either due to physical limitations or cognitive status.\textsuperscript{31} If the care recipient wanders (associated with Alzheimer’s disease) or displays unsafe behavior, the caregiver has to be alert and on call for supervision 24 hours per day. The constant concern for managing disruptive behaviors (such as turning on stoves, walking into the street, taking too many pills, yelling, screaming, or cursing) also affects the caregivers negatively.

Research Evidence: Interventions for Caregivers as Clients

The literature provides substantial evidence that caregivers are hidden patients in need of protection from physical and emotional harm. Interventions directed to the family caregiver should serve two purposes (see Evidence Table). First, interventions can support the caregiver as client, directly reducing caregiver distress and the overall impact on their health and well-being. In this intervention approach, the caregiver is the recipient of the direct benefit and the patient benefits only secondarily. Second, interventions can be aimed to help make the caregiver become more competent and confident, providing safe and effective care to the patient, which can indirectly reduce caregiver distress by reducing their load or increasing their sense of certainty and control. In this section, we focus on the research evidence supporting caregivers as clients.

Despite the importance of information and support to help family caregivers, studies on interventions to increase support for family caregivers have lagged far behind those provided for patients. A focus on the family as a part of the patient’s therapeutic plan of care is largely absent from interventional research and from general clinical practice.
as well. Few randomized clinical trials of educational interventions directed toward family caregivers have been conducted or published, and there is limited research to inform us about skills training for caregivers to prevent back injuries, infection, and other potential risks inherent in the caregiver situation.

**Evidence-Based Practice Implications**

A review of the literature found that society depends on family caregivers to continue providing care for their loved ones, but does little to teach them how to do it and support them in this stressful work. At a minimum, nurses can recognize and respect their efforts, assess their needs, provide concrete instructions on the specific care they are giving (e.g., medication administration, dressing changes, and similar tasks), and refer them to potential sources of ongoing help. Nursing interventions in these areas can help reduce harm to caregivers and the patients they serve.

**Respecting the Patient–Family–Professional Triad**

The most important practice implication of this review of caregiving research evidence is that nurses can meaningfully change the course of caregiving for both the caregiver and care recipient by respecting the role that each has in managing ongoing care beyond the classic boundaries of professional patient care. For example, it is often not easy for the elderly patient in the hospital who is going to need postacute care to accept the need for family help, because they view themselves as independent. Nurses can help shift their views of classic independence as freedom from functional limitations to a context of family care in which giving and receiving assistance does not need to strip away autonomy. It is also important to understand that burdened caregivers can successfully support their family member, but these caregivers may need help to bolster their sense of self-esteem. They want to be part of the decisionmaking team. Nurses in all practice settings need to partner with patients and their families to move from the traditional nursing context of doing for clients in the “expert model of service delivery” to more mutuality in nurse-client relationships. Nurses may need to “enact more empowering partnering approaches” and “reframe their professional image, role, and values” to accomplish this. Listening skills and the ability to interpret body language and verbal communication are essential competencies in all encounters with patients and their family members.

This model is consistent with Dalton’s theory of collaborative decisionmaking in nursing practice triads, where the triad comprises the client, the nurse, and the caregiver. In this vision of the caregiving environment, the nurse interacts with and assists not only consumers, but the informal caregiver as well. This kind of collaboration can increase feelings of control over health, the sense of well-being, and compliance with prescribed treatments.

**Providing Information**

Nurses need to communicate effectively with clients and caregivers to develop cost-effective plans of care and achieve positive client outcomes. Communication is crucial across settings. The emergency room and hospital discharge planning processes, assisted living facility admission process, skilled nursing facility discharge process, and the home health care admission and discharge process are all critical points of interaction where health care professionals, patients, and family caregivers can benefit from respectful, high-quality communication. In the managed care environment, providing concrete care information along with emotional support can help spouses of frail older adults better manage their caregiving situation.

At all points in the patient’s disease trajectory, caregivers need information to deal with the patient’s care and treatment demands. Nurses and other health care providers should not expect caregivers to be responsible for sorting out relevant information and applying it to the care requirements for their family members. Research documents that caregivers have difficulty obtaining information from health care professionals, particularly physicians and nurses. Professionals should be more responsive to patients’ and family members’ information needs.

It is important to provide information in a clear, understandable way through verbal, written, and electronic methods. Caregivers want concrete information about medications, tests, treatments, and resources. They also want time to have their questions answered. Nurses can provide anticipatory guidance for what the caregiver can expect. This kind of information can relieve caregivers’ distress arising from uncertainties about their ill family members’ disease and treatment status and the care they may need. For example, teaching caregivers how to manage pain and other symptoms benefits both the patient and the caregiver. Caregivers who report more confidence in managing symptoms report less depression, anxiety, and fatigue.

**Caregiver Assessment**

Given caregivers’ essential role in caring for their family members and the hazards they face in doing so, their connection to the health care system is often tenuous.
needs and capacities to provide care should be carefully assessed. This assessment should focus on the caregiver as both client and provider before health professionals can assume caregivers are able to provide competent care without harming themselves or their family member.

Assessing the home and family care situation is important in identifying risk factors for elder abuse and neglect. Heath and colleagues found that in-home geriatric assessments are needed to determine the risk for and occurrence of elder care recipient mistreatment. Fulmer’s research documents the need for interdisciplinary teams in emergency rooms to screen for elder neglect, with attention to risk factors associated with caregiver and elder vulnerability, such as the elder’s cognitive and functional status and depression. Health care professionals who conduct detailed assessments of the caregiving situation through separate conversations with the patient and the caregiver are better prepared to provide guidance and collaborate with the family to prevent abuse and neglect.

Assessing the needs of older people living in the community is a prerequisite for helping caregivers find resources and adhere to a comprehensive plan of care. Outpatient geriatric evaluation and management can reduce caregiver burden, particularly for those who are less experienced caregivers.

Linking Caregivers to Resources

Caregivers need adequate resources to assure minimization of risk to the patient. To reduce the rough crossing that family caregivers experience as they navigate the discharge from hospital to home, there is a clear need to develop referral criteria and guidelines, accurate documentation, and prompt referral to continuing care professionals. More case management programs may be useful to help ease this transition, promote safe and effective hospital discharges, and support caregivers in their ongoing, posthospital care. Nurses, preferably those trained in gerontological nursing, have a key role in case management for frail older people.

Linking caregivers to resources throughout the disease trajectory is important because caregivers are often unaware that there are support services available to help them. A recent study of caregivers of people with Alzheimer’s disease found that 75 percent had unmet needs, yet only 9 percent had used respite services and only 11 percent had participated in support groups. Extending nursing care beyond the hospital boundary, nurses can help caregivers mobilize supportive resources in their natural network as well as formal services.

Conclusion

Family caregivers are critical partners in the plan of care for patients with chronic illnesses. Nurses should be concerned with several issues that affect patient safety and quality of care as the reliance on family caregiving grows. Improvement can be obtained through communication and caregiver support to strengthen caregiver competency and teach caregivers new skills that will enhance patient safety. Previous interventions and studies have shown improved caregiver outcomes when nurses are involved, but more research is needed. There is more to be learned about the effect of family caregivers on patient outcomes and areas of concern for patient safety. Nurses continue to play an important role in helping family caregivers become more confident and competent providers as they engage in the health care process.

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Professional Liability Insurance: Pros and Cons

August 19, 2009 from 7pm to 8:15pm ET
Speaker: Rebecca Cady, RNC, BSN, JD, Attorney at Law

Nursing License Compact: Pros and Cons

September 16, 2009 from 7pm to 8:15pm ET
Speaker: Carol A. Roe, RN, MSN, JD, Attorney at Law

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